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	085032	A. BUILDING _____ B. WING _____	JUN 15 2010 05/03/2010

LTC Residents Protection

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE HEALTH	1175 MCKEE ROAD DOVER, DE 19904

Director's Office

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from April 26, 2010 through May 3, 2010. The deficiencies contained in this report are based on observations, staff and resident interviews, clinical record reviews, review of facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was fifty-eight (58). The survey sample totaled thirty six (36) residents.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations in the assisted dining room on 4/26 and 4/29/10, it was determined that the facility failed to provide a dignified dining experience for eight residents (R22, R8, R111, R17, R9, R41, R31 and R42) out of 36 sampled residents. Residents were observed watching other residents eat while they waited for assistance and staff were observed standing over residents while feeding. Findings include: 1. Observations were made of R22 during the evening meal on 4/29/10. The last tray distributed for the assisted dining area was at 5:16 PM. R22, who was coded as needing extensive assistance for eating on the quarterly MDS assessment dated 4/11/10, did not receive assistance with her meal until 5:42 PM. In the	F 241	F 241 A. Residents #22, #111, #17, #9, #41, #31, and #42 are receiving care in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality. The above residents have been provided with a dignified dining experience as coded on each resident's MDS assessment and are incorporated into the Dining Services Model changes. Resident #8 is no longer in the facility. Residents that need assistance with eating are receiving assistance and timely delivery of meals. Trained staff members are sitting at the table with the residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]		6/15/10

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F 241	Continued From page 1 mean time, R22 sat at the table watching her table mates being assisted with their meals. 2. Observations were made of R8 during the evening meal on 4/29/10. R8, who was coded as needing one person assistance for eating on the MDS assessment dated 2/01/10, did not receive assistance with her meal until 5:42 PM. In the mean time, she sat at the table watching her table mates being assisted with their meals. 3. Observations were made of R111 during the evening meal on 4/29/10. Resident R111, who was coded as needing one person assistance for eating, on the admission MDS assessment dated 4/23/10, did not receive assistance with his meal until 5:49 PM. In the mean time, he sat at the table watching his table mate being assisted with her meal. 4. R17, who was coded as needing extensive assistance with eating on her quarterly MDS, dated 2/19/10 was observed during the mid-day meal on 4/26/10. At approximately 12:00 PM, R17 was observed seated in a gerichair at a table with another resident with her meal tray on the table in front of her uncovered. The other resident at the table was observed eating his meal independently. Approximately 15 minutes later, staff came over to R17 to assist her with eating her meal. 5. R42, who was coded as needing extensive assistance with eating on her quarterly MDS, dated 1/20/10 was observed during the mid-day meal on 4/26/10. At 12:35 PM, R42 was observed seated at a table with another resident who was being assisted by a family member. R42's meal was on the table in front of her	F 241	B. Other residents identified to be affected by the dining experience are receiving care in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality and are provided a dignified dining experience as coded on each resident's MDS assessment and are incorporated into the Dining Services Model changes. C. The dining experience at this facility has been enhanced to meet individual resident needs and preferences. Education to the dining room and nursing staff has been provided by the Staff development Coordinator and/or the Food service director/designees regarding	

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F 241	Continued From page 2 covered. R42 was observed reaching for the lid on her entree several times. At 12:52 PM, staff was observed approaching R42 and began assisting her with her meal. 6. During the mid-day meal at approximately 12:30 PM on 4/26/10 in the assisted dining room, E27 (nurse) was observed standing while feeding R9. 7. . During the mid-day meal at approximately 12:30 PM on 4/26/10 in the assisted dining room, E29 (Certified Nurse Aid/CNA) was observed standing while feeding R8. 8. During the mid-day meal at approximately 12:30 PM on 4/26/10 in the assisted dining room, E29 was observed standing while feeding R41. 9. During the mid-day meal at approximately 12:30 PM on 4/26/10 in the assisted dining room, E30 (CNA) was observed standing while feeding R31.	F 241	proper dining room etiquette that enhances the resident's dignity and dining experience. D. Dining room audits will be completed 5 days/week x 4 weeks to ensure compliance. Variances will be corrected and results will be reported to the QA committee for review. Attachments #1 and #2	6/15/10
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made during the environmental tour with the maintenance director and maintenance supervisor on 4/29/10, it was determined that the facility failed to provide maintenance and housekeeping services necessary to maintain a sanitary and comfortable	F 253	F 253 A. Repairs were made to Rooms #202, #203, #204, #208, #211, #221, #222, #226, #231, and #233. Shower room walls will be repainted. Facility wheelchairs have been cleaned. B. Daily room audits are conducted on the Health	

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F 253	Continued From page 3 interior as reflected by unpainted/damaged walls, dusty wheelchairs, and furniture/fixtures in disrepair. Findings include: 1. Scratched, damaged, unpainted plaster, stained or dirty walls were observed in resident rooms 202A, 203, 204, 208, 211A, 226, 231, 233, 234. An interview with maintenance staff (E13, maintenance director and E14, maintenance supervisor) confirmed this finding. 2. Five (5) of ten (10) resident wheelchairs reviewed were observed dirty/dusty for residents R13, R47, R64, R78, R84 in the dining room area. 3. The bed of resident R25 was in disrepair. The maintenance director (E13) tried to fix the bed during the tour and confirmed the bed was in disrepair. 4. Resident personal clothing storage closet doors and two-drawer chest doors in resident rooms 203, 218, 233 were in disrepair. 5. The clean linen storage rack covers on the hallways of the three resident units were observed in disrepair. 6. Privacy curtains in resident rooms 221 and 222 were observed in disrepair. 7. Yellow stained walls were observed in the East and West unit Tub rooms of the facility. The areas around the whirlpool and the shower walls were stained yellow. Staff interview with maintenance staff (E14) revealed that a contractor was working on the walls. A work order for this project was requested but not provided.	F 253	Care Rooms. When concerns are found, a work order is generated and closed on a timely manner. C. A daily checklist is being completed by the housekeeping staff to observe for a rooms or furniture that may need to be repaired. Follow-up will be done by the maintenance staff to ensure repairs timely. A wheel chair cleaning schedule has been developed and implemented to ensure wheelchairs are thoroughly cleaned on a rotating schedule. Maintenance Director/designee will educated housekeeping, maintenance and nursing staff regarding proper procedure for obtaining work orders for repairs, and	

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F 253	Continued From page 4 8. Observation of resident room 233 on 4/29/10 at 11:30 AM revealed a section of the wall heater element in the bedroom was uncovered. The protective plate was not covering the element. During the initial tour, a heater protective plate was lying on the floor of resident room 232A and the heater element was uncovered. This represented a hazard to the residents and staff in that room.	F 253	wheel chair cleaning schedule. D. Audits of rooms will be completed daily with the cleaning schedule to ensure rooms and furnishings are in good repair 5 days/week x 4 weeks. Variances will be corrected. Results of audits and progress will be reported to the QA committee. Attachments #3, #3A, #4, and #5	6/15/10
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for four (R110, R40, R102, and	F 279	F279 A. Residents #40 and # 102 have had their care plans revised to meet their needs as identified in their comprehensive assessments. Resident #40 – Care plan was updated on 4/29/10 to include problem of being an	

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F 279	Continued From page 5 R51) out of 36 sampled residents the facility failed to develop a comprehensive care plan for an identified resident care area. The facility failed to implement care plan for an indwelling Foley catheter for R110 and R102. The facility failed to implement a care plan for R40's behavior symptom of anxiety and failed to implement a care plan for R51's activity pursuits Findings include: 1. R110 admitted to the facility on 4/23/10 with indwelling Foley due to urinary retention. Review of R110's interim care plans lacked evidence of a care plan for the maintenance of a Foley catheter. An interview with the Registered Nurse Assessment Coordinator (E4) on 4/29/10 at 12 noon confirmed the lack of this care plan. 2. Cross refer F329 example #2 On 12/14/09, R40 was ordered Xanax .50 mg. (anti-anxiety medication) one tablet by mouth every 8 hours as needed for behavior- anxiety. On 1/23/10, R40 had a physician order for Xanax .25 mg by mouth daily 30 minutes before PT (physical therapy)/OT (occupational therapy). Review of R40's care plans revealed that the facility failed to develop a care plan for R40's anxiety problems with approaches that included non-pharmacological interventions as well as the use of Xanax. On 4/29/10 at 6:59 PM, an interview with the Social Worker (E3) confirmed that R40 was not care planned for her behavior symptom of anxiety. 3. R102 was admitted to the facility post	F 279	Anti-anxiety medication for generalized anxiety. Care plan further updated to include additional non-pharmacological approaches. Resident #102 – A care plan for an indwelling urinary catherer related to urinary retention was initiated for R102. Resident #51 and Resident #110 no longer reside in the community. B. Resident's care plans were audited and were found to meet resident's needs as identified in their comprehensive assessment. C. Staff Development Coordinator/designee will educate nursing staff regarding proper care planning procedure. Care plans will be reviewed 5xwk at morning meeting to ensure inclusion of new	

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F 279	Continued From page 6 hospitalization on 3/8/10 and had a diagnosis of neurogenic bladder. Upon admission, R102 had an indwelling (Foley) catheter which was subsequently discontinued. R102's clinical record revealed that on 4/26/10 the resident had a physician's order for the reinsertion of an indwelling (Foley) catheter. Review of R102's care plan lacked evidence of the development of a care plan for the Foley catheter. During an interview on 5/3/10, E4 (nurse) acknowledged the lack of a care plan for R102's indwelling catheter. 4. Review of R51's "Activity Assessment" dated 2/28/10, indicated R51's interests included cards/other games, crafts/arts, music, spiritual/religious activities, walking/wheeling outdoors, talking or conversing. The focus of programming was to include: 1:1 activities, creative/expressive activities, community outings, group games, religious activities, social interaction activities, talk oriented activities. A care plan for problems of "resident crying in activities" with last revision date of 3/11/10 indicated a goal that R51 "I will not cry while in activities daily times 90 days" The approach or intervention included "music in the great room, if upset talk to me in a quiet manner and rub my arm and at times need someone close to me; need to be in contact with my daughter". Although the facility implemented a care plan to address R51's behavior of crying in activities, the care plan failed to include the assessed activity pursuit of R51. During an interview on 4/30/10 at 4:30 PM with	F 279	interventions as they occur. Care plans will be reviewed at least quarterly with MDS completion. D. An audit will be completed weekly x 4 weeks to ensure care plans are inclusive of intervention identified in comprehensive assessments. Variances will be corrected and results reported to the QA committee Attachments #6A and #7	6/15/10

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F 279	Continued From page 7 the Activity Director (E11) confirmed that the above care plan was related to R51's behavior of crying and did not include R51's activity pursuits and measurable goals.	F 279	F280 A. Care plans for Resident #40 was revised to include new approaches/interventions to prevent further falls and to prevent the level of the injury. The resident's care plan was also updated to include "Provide 1 person minimal assist with rolling walker for toileting". Resident #13 – Care plan approach for skin breakdown from "non-weight bearing to right heel" was changed to read, "may wear regular shoe when ambulating and pressure relief boot when not ambulating". B. Resident's care plans were audited and interventions in place were appropriate to resident's current needs.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview it was determined that the facility failed to review and revise the care plans for two (R40 and R13) out of 36 residents sampled. Findings include: 1.a. R40 had a care plan dated 12/31/09 for "Resident at risk for falls" with a goal of "Resident will remain free from new injury daily X 90 days	F 280		

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F 280	Continued From page 8 3/31/10." R40 fell twice on 3/18/10. There was no documentation indicating the facility reviewed and revised R40's care plan after the 3/18/10 fall to include new interventions and approaches to prevent further falls. b. R40 had a care plan dated 12/31/09 for "Resident has Occasional Urinary Incontinence" with an approach "6. provide 2 person physical assistance for toileting." R40's MDS assessment dated 3/3/10 revealed R40 required one person assistance for toileting. The facility failed to revise the care plan to include this change in assistance. 2. R13 had a care plan dated 12/2/09 for "Actual Skin Breakdown" with approaches which included "Non weight bearing to right heel." On 12/21/09, the physician ordered "Full weight bearing on right foot when out of bed with splint in place." The facility failed to review and revise R13's care plan to change the weight bearing status.	F 280	C. Staff development coordinator/designee will educate nursing staff regarding proper care planning procedures. Care plans will be reviewed 5x/week as necessary at morning staff meetings to ensure inclusion of new interventions as they occur. D. An audit will be completed weekly x 4 weeks to ensure care plans are inclusive of new interventions as needed. Variances will be corrected and results reported to the QA committee for review. Attachments #6B and # 7	6/15/10
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, interview, review of the facility's policy and procedure and review of the facility's nursing manual for staff use, it was determined that the facility failed to provide services which met professional standards of practice for the care and service of a pressure ulcer for one (R13) out of 36 residents sampled. Findings include:	F 281	F281 A. Resident #13 had no ill effects from dressing change done on 4/28/10.	

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F 281	Continued From page 9	F 281		

Cross refer F314 and F441 example #3.

The facility's policy and procedure for handwashing stated "Hands should be washed ... Before and after each procedure or task, Before and after handling medications, Before and after the use of gloves,..."

The facility's policy and procedures for wound care stated "4. Measure and document wounds weekly."

The Lippincott Manual of Nursing Practice (7th Edition) stated "Equipment Unsterile- gloves, plastic bag for discard dressings, tape, proper size and type, pads to protect patient's bed. Procedure 5. Wash hands thoroughly. 6. Place dressing supplies on a clean, flat surface (over bed table). 7. If linen protection is needed, place clean towel or plastic bag under part of body where wound is located. 9. Place disposable bag nearby to collect soiled dressings. 10. Determine how many and what types of dressings are necessary. Open each dressing by peeling apart the edges of package."
R13 had a physician order on the April 2010 physician order sheet originating 11/25/09 to "Cleanse area, pat dry, apply dry dressing to right heel. Allow eschar to dry and come off at edge. Change daily."

On 4/28/10 at 4:00 PM E9 (Licensed practical nurse) was observed doing a pressure ulcer dressing change to R13's right heel. Observation of the dressing change revealed E9 did not wash his hands after changing his gloves or after the completion of the dressing change. E9 went to the medication cart and started to

Res. #13 wounds are being assessed for proper treatments and are being measured weekly. The LPN was educated on wound dressing change as well as all the licensed nurses. The LPN had to also demonstrate the wound dressing change procedure.

B. Residents who have wounds are being measured weekly and treatments are appropriate. Dressing care is being provided meeting professional standards.

C. Staff Development Coordinator/designee will educate professional nursing staff regarding proper dressing change techniques. A guideline for clean dressing change is now being followed. Weekly wound measurements are being

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F 281	Continued From page 10 pass out medications without washing his hands. Handwashing was not done according to the facility's policy and procedures. The disposal of the old dressing along with the gauze used to cleanse the wound were placed on the floor instead of in a trash bag. E9 used the bed to place his clean dressings on instead of a clean area. E9 used his forearm to unroll the Kling (rolled guaze) dressing before placing it on R13. E9 used scissors from his pocket to cut off the old dressing then replaced them back in his pocket without cleaning the scissors. Review of this observation with E9 at the completion of the dressing change confirmed surveyor's observation. The facility failed to measure R13's wounds weekly as indicated by their own policy to evaluate the interventions and treatment of the pressure ulcer. R13's wound measurements were documented as follows: In 2009- 9/30/09 then 15 days later on 10/15, then 31 days later on 11/5, then 20 days later on 11/25, then one week later on 12/2, then 9 days later on 12/11, then 20 days later on 12/31/2009 In 2010 1/6 then 14 days later on 1/20, 1/28, 2/4, then 13 days later on 2/17, 2/25, 3/4 then 15 days later on 3/19, then 12 days later on 4/1, 4/8, 4/15, 4/22/2010. On 4/29/10 at 12:00 PM E2 (Corporate Nurse) stated the facility did not have a policy and procedure for a clean dressing change for the staff to follow. E2 continued to state the facility had a Lippincott manual but was unable to find a clean dressing change process in the manual.	F 281	done by the wound team. Treatments and interventions are discussed with IDT as needed during facility weekly "at risk" meetings. D. DON/designee will audit wound measurements weekly to ensure compliance. SDC/designee will do random dressing change observations to ensure proper techniques. Variances will be corrected and audit results will be presented to the QA committee for review. Attachments #8, #9 and #25	6/15/10
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309	F309 A. Resident #55 continues to receive care that meets the highest practical physical, mental and psychosocial	

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F 309 SS=D	Continued From page 11 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview it was determined that the facility failed to ensure that one (R55) out of 36 sampled residents received the care and services to maintain the highest practicable physical, mental, and psychological well-being in accordance with the plan of care. The facility failed to follow the physician's order and applied a portable blood pressure cuff on R55's upper left arm where the hemodialysis graft (an access for dialysis) is located for her dialysis. Findings include: On 4/29/10 at approximately 3:30 PM, the surveyor observed a staff nurse (E22) who applied a portable blood pressure cuff on the upper arm of R55. The surveyor advised E22 that R55 has a dialysis graft in the upper left arm. E22 immediately removed the blood pressure cuff, proceeded to review R55's electronic treatment record which noted "no blood pressure or lab draws on the left arm" due to the hemodialysis graft. E22 confirmed that she should not have applied the cuff to take R55's blood pressure.	F 309	well being in accordance with the comprehensive assessment and plan of care. There were no ill effects from the blood pressure monitoring observed. B. No other residents with hemodialysis graft in the facility. C. Staff development coordinator/designee will educate professional license nursing staff to follow the physician's order and follow proper procedure when taking blood pressure where the hemodialysis graft is located for dialysis. The CNAs do not take vital signs on residents with blood pressure medications or with a hemodialysis graft. D. Daily random audits to observe monitoring of blood pressures will be	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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F 314	Continued From page 12 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview it was determined that the facility failed to provide the necessary services for an unstageable pressure ulcer for one (R13) out of 36 residents sampled. R13's right heel pressure ulcer was not measured weekly and documented . Findings include: The facility's policy and procedures for wound care stated "4. Measure and document wounds weekly." R13 was admitted to the facility on 11/18/09 with a stage IV pressure ulcer which she acquired while living in assisted living. R13 had a non medicated treatment physician order dated 12/9/09 "Measure and record to heel right 3-11 shift weekly special instructions: document the size of area on (computer program) skin grid." Review of the skin grid program for R13's pressure ulcer measurements and documentation of her right heel revealed the right heel pressure ulcer was measured and documented as follows: In 2009- 9/30/09 then 15 days later on 10/15,	F 314	done by the DON/designee 3 x/week for 4 weeks. Variances to procedure will be corrected immediately. Results of audits will be reported to the QA committee. Attachment #10 F314 A. Resident #13's pressure ulcer is being measured and assessed on a weekly basis. B. Residents with pressure ulcers continue to be assessed for proper treatment to their wounds and wounds are being measured, observed and assessed at least weekly. C. Staff development coordinator/designee has educated the professional nursing staff regarding the	6/15/10

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F 314	Continued From page 13 then 31 days later on 11/5, then 20 days later on 11/25, then one week later on 12/2, then 9 days later on 12/11, then 20 days later on 12/31/2009 In 2010 1/6 then 14 days later on 1/20, 1/28, 2/4, then 13 days later on 2/17, 2/25, 3/4 then 15 days later on 3/19, then 12 days later on 4/1, 4/8, 4/15, 4/22/2010. The facility failed to follow the physician orders and their policy and procedures for measuring, documenting and staging the pressure ulcer weekly. On nine different occasions, the measurement of the pressure ulcer was longer than one week apart. Review of the information with E10 (Registered Nurse Supervisor) on 4/29/10 at 4:35 PM confirmed the surveyor's findings.	F 314	facilities policy on weekly wound measurement and assessments. Weekly wound rounds, measurements, dressing change observations and compliance with infection control standards are being done by the charge nurse/designee. D. Audits of wound measurement and assessment documentation are being done weekly by the DON/designee to ensure compliance x 4 weeks. Variances to the policy will be corrected immediately. Results of the audits will be reported to the QA committee. Attachments #8 and #11	6/15/10
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that two residents (R32 and R102) out of 36 sampled residents received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Findings include:	F 318		

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F 318	Continued From page 14 1. R102 was admitted to the facility on 3/8/10 post hospitalization for rehabilitative services. R102 was discharged from skilled therapy services on 4/7/10. A copy of a "Restorative/Maintenance Referral," dated 4/7/10, was provided by physical therapy (PT). This referral stated that R102 was to receive Passive Range of Motion (PROM) 2 times daily to both upper and lower extremities with the goal being "..will maintain/improve upper extremity/lower extremity (UE/LE) ROM to decrease risk of contracture and facilitate ADLs (activities of daily living)." Review of the nursing restorative book revealed that R102 was not receiving PROM to the UE/LE twice daily as recommended by PT. During an interview with E10 (nurse) on 4/27/10 she confirmed that R102 was not receiving any restorative/maintenance services. In an interview with E20 (PT) revealed that when a referral was written it was given to the Assistant Director of Nursing (ADON), who then contacted the physician for an order and placed a sheet specifying the services the resident was to receive in the nursing restorative book. Once entered into the restorative book the Certified Nurse Aides (CNA) would then know which resident was to receive restorative services. The facility's ADON was not present at the facility during the survey and therefore was not able to be interviewed. The facility failed to ensure that R102 was receiving appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318	F318 A. Residents #32 and 102 are receiving restorative nursing programs as per physician order. No ill effects occurred from delay in restorative programming. B. A review of residents in the facility showed that residents with physician orders for restorative nursing are receiving the appropriate programming to prevent contractures. C. Physical Therapy department will alert nursing staff at morning meeting when a resident is completing a course of therapy and will require continuation of a restorative nursing program. The charge nurse will obtain physician orders and program implementation	

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F 318	Continued From page 15 2. R32 was admitted to the facility on 1/26/10 with diagnoses that included hypertension and congestive heart failure. Review of the clinical record revealed that R32 was discharged from physical therapy (PT) services on 4/19/10. The PT discharge summary, dated 4/20/10, stated that the recommended services upon discharge were "Restorative Nursing/Maintenance Program." On 4/20/10 a referral was completed by PT which stated that R32 was to have PROM three times a day and additionally, was to ambulate twice a day a distance up to 150 feet with the use of a rolling walker and 1 person assist. Review of the nursing restorative book lacked evidence that R32 was receiving PROM three times a day and being ambulated twice a day. In an interview with E10 (nurse) on 4/27/10, she stated that R32 was not receiving any restorative nursing services. During an interview with E20 (PT) on 4/27/10, she stated that the referral had been given to the ADON to obtain physician orders, however this was never followed through. The facility failed to ensure that R32 was receiving appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion.	F 318	will then begin. Staff development coordinator/designee with educate the professional nursing staff regarding this process. D. An audit will be done 5x/wk during morning meeting to ensure compliance with recommendations from Therapy to nursing for restorative programming. Results will be reported to the QA committee. Attachment #12 and #12A	6/15/10
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and	F 325	F325 A. Resident # 40, #10, #17, and #68 were re weighed to establish a baseline. Resident weights have been evaluated and remain stable and within acceptable	

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F 325	Continued From page 16 (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews and review of facility policy, it was determined that the facility failed to maintain acceptable parameters of nutritional status such as body weight for one (R40) of 36 sampled residents. The facility failed to identify a significant weight loss for R40 for three weeks and failed to implement interventions to address the weight loss. Additionally, the facility failed to have a system in place to verify and analyze weight changes in a timely manner as evidenced by weights obtained for five additional residents (R10, R17, R68, R8 and R98) of 36 sampled residents. Findings include: The facility policy entitled, "Weights" was reviewed. Under the guidelines it stated that weights were to be, "Taken on a designated chair, with designated equipment... " and "...Variances of plus or minus 5 pounds or more for residents over 100 pounds or plus or minus 3 pounds or more for residents under 100 pounds require: A re-weigh within 24 hours; A report, by the charge nurse, to the physician, dietician, and responsible party..." Under the procedures it stated that staff obtaining the weight "...Report the weight to the licensed nurse who shall determine if loss or gain occurred..." 1. R40 was readmitted to the facility on 12/14/09 with diagnoses including anxiety disorder,	F 325	parameters of nutritional status. Resident #8 no longer resides at the facility. As per the Weight Policy (Attachment #13) the Registered Dietician (RD) will be notified by nursing staff for follow up consult for weight variances. The RD's recommendation will be reviewed by nursing staff and follow up with the attending physicians for orders as appropriate. B. A review of monthly and weekly weights is done by the DON/Designee to determine variances. DON/Designee will audit resident weight the first week of the month to ensure compliance and ensure necessary re weights and dietician recommendations have been obtained. Weight variances will be	

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F 325	Continued From page 17 dementia, hypertension and history of a hip fracture. Review of R40's weight record revealed the following: 12/28/09 - 112 lbs. 1/1/10 - 88.5 lbs. (20% weight loss in 4 days) 1/6/10 - 113.9 lbs. (reweight) 1/11/10 - 112 lbs. 1/14/10 - 111.4 lbs. 2/15/10 - 112 lbs. 3/15/10 - 113 lbs. 3/29/10 - 110.4 lbs. 4/5/10 - 98.5 lbs. (10% weight loss in 1 week) 4/12/10 - 111.5 lbs. 4/19/10 - 98.6 lbs. (11% weight loss in 1 week) 4/26/10 - 96.7 lbs. 4/29/10 - 99.4 lbs. (9% weight loss in 1 month) 5/3/10 - 98.9 lbs. (observed by the surveyor) R40's Physician Order Form, dated 5/3/10, indicated that she had been receiving Ensure Plus supplement three times a day since 1/8/10. R40's care plan, 12/17/09, identified the problem, "Nut (nutritional) risk R/T (related to) leave 25% uneaten at most meals. Potential for dehydration R/T recent UTI (urinary tract infection)." The goal stated that the resident would, "Maintain or increase wt (weight) 1-2#/mo to 5# in 90 days..." Approaches included encouragement for the resident to consume >/= 76% of meals, to monitor meals and record, to weigh monthly or per protocol and record, and to report significant change to RD and MD. Review of R40's Nutritional Assessment, dated 12/17/09 revealed that her admission weight was 117 lbs. The dietary note written upon admission	F 325	discussed with the interdisciplinary team at morning meeting 5x/week and residents at risk for nutritional deficits will be reviewed by the IDT at facility weekly "at risk" meetings. C. Residents have been scheduled for monthly weights the 1st Monday, Tuesday, or Wednesday of each month. Staff has been educated to follow the current policy and will be audited to maintain compliance of the policy and procedure. The weight policy and procedure was not followed by the staff due to lack of understanding. Nursing staff have been educated on the facility weight policy by the staff development coordinator/designee.	

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F 325	Continued From page 18 on 12/14/09, stated that the resident had no edema (swelling) and that she was a good eater prior to her hospital admission. A subsequent note, dated 12/17/10, recommended the addition of a nutritional supplement, Ensure Plus three times a day since the resident was consuming < 75% of her meals. Subsequent nutrition notes on 1/6/10, 1/27/10 and 3/3/10 indicated that weight and intake monitoring would continue and no new recommendations were made. The next dietary note was dated, 4/28/10 and was written by a different dietitian who was filling in for the facility's regular dietitian who was on vacation. The note stated that R40's 4/26/10 weight indicated a significant weight loss from the previous month despite the resident receiving 3 Ensure Plus supplements a day. It stated that the resident, "May require additional assistance at mealtimes." No other interventions were recommended. However surveyor observations during the survey revealed the resident ate independently. Observations of R40 at meals during the survey from 4/28/10 through 4/30/10, revealed that the resident ate independently without assistance. Review of R40's meal intake records from 4/1/10 through 4/24/10, indicated that she consumed an average of 50% of her meals. Her Medication Administration Record, dated 4/1/10 through 4/30/10, showed that she usually drank 100% of the supplements given. During an interview with E5 (dietitian) on 5/3/10, she stated that she did not request a reweight for R40 after her 4/19/10 weight which indicated a weight loss of 12.9 lbs. in one week because she assumed that it was an error. This was why she failed to contact the resident's physician. E5 stated that she was planning to wait to see what	F 325	Dietician will be notified by nursing staff for follow up consult for weight variances. Dietician recommendations will be reviewed by nursing staff and follow up with physician for orders as appropriate. D. DON/designee will audit resident weights the first week of the month to ensure compliance and ensure necessary re-weights and dietician recommendations. Weight variances will be discussed with the interdisciplinary team at morning meeting 5x/wk and residents at risk for nutritional deficits will be reviewed with the IDT at facility weekly "At Risk" meetings. Results of audits will be reported to the QA	

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F 325	Continued From page 19 her monthly weight would be the first week of 5/10. The facility failed to have a system in place to identify weight changes and obtain reweights in a timely manner as per their policy. Nursing failed to monitor weights and alert the dietitian and physician to significant weight changes causing a delay in the analysis of the reason for the loss or gain. The facility initially failed to identify a significant weight loss for R40 on 4/5/10 and 4/19/10. When it was finally identified on 4/26/10, no new interventions were implemented to address the weight loss other than the recommendation for additional assistance. Cross refer F327 2. Review of R10's weight record revealed the following: 10/5/09 - 137.9 lbs. 11/30/09 - 130 lbs. (5% loss in 1 week) 12/23/09 - 132.5 lbs. 1/25/10 - 130.4 lbs. 1/27/10 - 135.7 lbs. 2/1/10 - 121 lbs. (10% loss in 5 days) 2/8/10 - 130.7 lbs. (8% gain in 1 week) 2/15/10 - 123 lbs. (5% loss in 1 week) 3/3/10 - 121 lbs. 4/22/10 - 122.6 lbs. R10's clinical record lacked evidence that a reweight was done to verify the three instances of significant weight loss. R10 was hospitalized on 2/19/10 for severe dehydration. 3. Review of R8's weight record revealed the following: 11/2/09 - 100.6 lbs. 11/9/09 - 116.9 lbs. (16% gain in 1 week)	F 325	committee on a quarterly basis. Attachments #13, #14, and #15	6/15/10

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F 325	Continued From page 20 12/23/09 - 113.4 lbs. R8's clinical record lacked evidence that a reweight was done to verify the resident's significant weight gain. 4. Review of R68's weight record revealed the following: 11/3/09 - 119.5 lbs. (chair scale) 12/3/09 - 123 lbs. (chair scale) 1/2/10 - 125.5 lbs. (chair scale) 2/1/10 - 129.9 lbs. (stand-up scale) 3/2/10 - 125.2 lbs. (lift scale) 3/3/10 - 131 lbs. (chair scale) 4/2/10 - 119.4 lbs. (chair scale, 8% loss in 1 month) R68's clinical record lacked evidence that a reweight was done to verify the resident's significant weight loss. Additionally, different scales were used to obtain weights on R68 making accuracy difficult to determine. Furthermore, the documentation makes it look like there were three different scales, when actually there were only two scales used (the stand-up scale is the same as the chair scale). 5. Review of R17's weight record revealed the following: 1/11/10 - 115 lbs. (chair scale) 1/18/09 - 121 lbs. (stand-up scale, 5% gain in 1 week) 2/1/10 - 121 lbs. (stand-up scale) 2/8/10 - 110 lbs. (chair scale, 9% loss in 1 week) 2/15/10 - 93 lbs. (stand-up scale, 15% loss in 1 week) 3/3/10 - 120.1 lbs. (lift scale, 29% gain in 2 weeks) 3/15/10 - 101 lbs. (stand-up scale, 15% loss in 12	F 325		

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F 325	Continued From page 21 days) 3/22/10 - 115 lbs. (chair scale, 13% gain in 1 week) 3/29/10 - 116.2 lbs. (chair scale) 4/5/10 - 118 lbs. (chair scale) 4/12/10 - 95 lbs. (stand-up scale, 19% loss in 1 week) 4/26/10 - 116.2 lbs. (chair scale, 22% gain in 1 week) R17's clinical record lacked evidence that reweights were done to verify the resident's significant weight changes. Additionally, different scales were used to obtain weights on R17 making accuracy difficult to determine. During an interview with E24 (Certified Nurse Aid/CNA), on 4/30/10, she stated that when the CNA's obtained a resident's weight, they entered it into their computer system but they did not compare it to the previous weight. She stated that the dietitian reviewed the weight weekly and then would let the CNA's know if a reweight was needed. Interview with E5 (dietitian) on 5/3/10 revealed that nursing was suppose to identify a weight change, but she stated that, "In reality, I do." She stated that after she identified the weight change she, she notified the Director of Nursing or the Assistant Director of Nursing so that a reweight could be obtained. E5 stated that she reviewed the residents' weight about four times a month, usually weekly. She verified that it could be a week before a reweight was obtained.	F 325		

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F 325	Continued From page 22 6. R98 was admitted to the facility on 3/2/10 due to right ankle fracture and had a cast. Record review revealed admission weight of 184 pounds (#) on 3/2/10 and only one other weight of 168.8 # (approximately 15 # or 8% loss from the previous weight) on 4/23/10 (approximately seven weeks since the initial weight). Record review lacked evidence of a weekly weight for four weeks or a reweight to verify the weight obtained on 4/23/10. Subsequent to the surveyor's inquiry on 4/30/10, the facility obtained R98's weight on 4/30/10 which was 170.2 # (approximately 13 # or 7.5% loss since admission). An interview with E5(dietitian) on 5/3/10 at approximately 1 PM revealed that E5 only had one weight on admission for R98 and was not notified of the approximately 15 # variance on 4/23/10. E5 related the confirmed weight loss on 4/30/10 was primarily due to the removal of the cast from the right ankle and intermittent loose bowels, however, she did confirm that the facility failed to obtain weekly weights for four weeks and failed to obtain a reweight following the 4/23/10 weight for R98. The facility failed to have a system in place to identify weight changes and obtain reweights in a timely manner as per their policy. The facility failed to monitor weights for all six residents listed above and failed to alert the dietitian and the physician to significant weight changes causing a delay in the analysis of the reason for the loss or gain. This resulted in a failure to immediately implement interventions for two residents, R40 and R10 to address their significant weight loss issues.	F 325		
F 327 SS=G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION	F 327		

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F 327	Continued From page 23 The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Cross refer to F325, example #2 Based on observations, interviews, record review, and review of facility policy, as well as hospital records, it was determined that the facility failed to ensure that one (R10) of 36 sampled residents received sufficient fluid intake to maintain proper hydration and health. The facility failed to identify that R10's fluid intake had declined and the facility failed to implement interventions to ensure adequate hydration to maintain health. R10 was hospitalized with acute renal failure due to severe dehydration. Findings include: The facility's policy entitled, "Hydration' was reviewed. R10 was admitted to the facility on 8/10/00 with diagnoses including alzheimer's dementia, chronic obstructive pulmonary disease and history of stroke. R10's quarterly Minimum Data Set (MDS) assessment, dated 2/12/10 indicated that his cognitive skills for daily decision making were "modified independence - some difficulty in new situations only." and he was coded as independent for eating. Observations of the R10 during the survey confirmed that he ate independently. R10's care plan for "Nutrition, risk potential, R/T	F 327	F327 A. Resident #10 fluid requirements needs were assessed and compared to his actual fluid consumption, baseline was established. B. Residents were placed on intake monitoring for 3 days. A subsequent audit was done comparing fluid requirement needs based on the dietician nutritional assessment. Those residents not meeting the fluid requirements were determined to be at risk. A nutritional evaluation "hydration risk assessment" was done on those residents. A baseline for fluid consumption requirements has been established.	

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F 327	Continued From page 24 (related to) mechanically altered diet.", dated 11/25/09, stated that the goal was, "Resident will maintain weight +/- 3 lbs. monthly and will show no signs of dehydration daily x 90 days." with a goal date of 3/2/10. One of the approaches listed was , "Encourage fluids. Off (offer) & enc (encourage) >/= (greater than or equal to) 120 ccs qid. (4 times a day) doc (document) consumed on MAR (Medication Administration Record). Give fluids of preference. Cola 8oz bid (twice a day) on snack list..." R10's Nutrition Assessment, dated 11/25/09, calculated his daily fluid needs to be 1770 ml. A dietary note of the same date noted a significant weight loss. E5 (dietitian) stated that R10's "...Fluid intake avg (average) 240 ml/meal, receives extra fluids between meals, consumes avg 80 ml..." She also noted that his beverage of choice was cola. Review of R10's Physician Order Record, dated 1/8/10, revealed orders to "Encourage Fluids, 120 ml, 4 times a day..." R10's MAR and Meal Percentages sheets for 2/10 were reviewed. His total daily fluid consumption from meals and during medication pass times were as follows" 2/1/10: 1430 ml 2/2/10: 1040 ml 2/3/10: 1640 ml 2/4/10; 1780 ml 2/5/10, 2/6/10 and 2/7/10: Could not be determined because no meals were recorded on those days 2/8/10: 1270 ml 2/9/10: 1060 ml 2/10/10: 780 ml	F 327	C. Staff has been educated regarding nutrition and hydration needs to maintain proper health of residents in long term care by the SDC/designee. Residents who are deemed at high risk for dehydration will be monitored and reviewed by the IDT at the "at risk" meeting as necessary. Appropriate interventions will be initiated as needed. D. Residents deemed at risk for dehydration will be monitored and assessed weekly x 4 weeks by the DON/designee and/or the Registered Dietitian. A report will be presented to the QA committee outlining results of monitoring. Attachments #16 and #17	6/15/10

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F 327	Continued From page 25 2/11/10: 940 ml 2/12/10, 2/13/10 and 2/14/10: Could not be determined because no meals were recorded on those days. 2/15/10: 1537 ml 2/16/10: 840 ml 2/17/10: 1040 ml 2/18/10: 780 ml Of the 12 days that total fluid intake was recorded for R10, he only came close to meeting his daily requirement on two days. From the beginning of the month until the day that R10 was sent out to the hospital on 2/19/10, his daily fluid consumption showed a downward trend. There was no evidence that anyone was monitoring his decreasing daily intake of fluids. R10's weight record indicated he had two periods of significant weight loss beginning 1/10 to 2/10. The weights changes were 135.7 lbs. on 1/27/10 to 121 lbs. on 2/1/10 (10%) and from 130.7 lbs. on 2/8/10 to 123 lbs. on 2/15/10 (5%). There was no evidence that reweights were done to verify the changes. A dietary note, dated 2/8/10, stated , "Good intake fluids -- mostly colas." The next dietary note, dated 2/18/10, stated that the RD spoke to the resident about his weight loss and "...Res (resident) said he would be willing to drink E+ (Ensure Plus), and, in fact, drank one this am..." Review of nurse's notes from 2/8/10 through 2/18/10 lacked evidence that R10's fluid intake had declined nor was there any mention that fluids were being encouraged. Additionally there was no evidence that nursing was monitoring for signs and symptoms of dehydration even after his	F 327		

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F 327	Continued From page 26	F 327		

significant weight loss.

A nurse's note, dated 2/19/10, stated, "Resident was reported to have poor PO (by mouth) intake...dry mucos (sic) membrane, poor skin turgor, resident is alert, MD notified, he gave order to send resident out to ER eval..."

Review of R10's hospital records revealed a physician's consult, dated 2/20/10, which stated, "...Unfortunately Mr (name) also has developed acute renal failure. His creatinine of 8.3 (normal range: 0.5 - 1.5) with a BUN (blood urea nitrogen) of 131 (normal range: 10 - 26) suggests predominately volume depletion and prerenal azotemia (accumulation of nitrogenous wastes usually caused by hypovolemia or low blood volume). Under the physical exam, the MD noted that the "..."Foley (catheter) reveals dark, concentrated urine, only 20 ml..." The assessment includes shock, dehydration and acute renal failure. A subsequent hospital physician consult, dated 2/22/10, stated that the BUN and creatinine were going down after hydration with intravenous (IV) fluids. Laboratory data noted that the BUN was 75 and the creatinine was 3.1. Under "Impressions/Recommendations", the MD stated "...Renal failure from dehydration, more of acute tubular acidosis and dehydration, causing the high BUN and creatinine than any kidney disease behind it, but it is hard to tell at this time, and we will need to hydrate him more to see the response..." Under, "Family History" the report stated, "There is no mention of renal disease in available records."

Subsequent lab values during R10's hospital stay were as follows:

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F 327	Continued From page 27 2/25/10: BUN - 33; Creatinine - 1.5 2/26/10: BUN - 22; Creatinine - 1.3 2/27/10: BUN - 19; Creatinine - 1.3 2/28/10: BUN - 16; Creatinine - 1.3 3/1/10: BUN - 15; Creatinine - 1.2 3/2/10: BUN - 15; Creatinine - 1.2 The hospital discharge summary dictated 3/2/2010 stated the discharge diagnosis was acute renal failure due to dehydration, diarrhea, colon distention, hypokalemia, hypomagnesemia, Alzheimer's dementia, history of hypertension and dyslipidemia. Under hospital course this same report stated the patient was admitted to (name of hospital) on 2/19/2010 with acute renal failure. Under lab data this report stated blood cultures on 2/19/2010 no growth. Urinalysis and urine cultures were nonrevealing. R10 was released from the hospital on 3/3/10 after his lab values came down to within normal limits following IV fluids. During an interview with E5 (dietitian) on 5/3/10, she stated that she tracked residents' fluid intakes at their annual assessments. She stated that extra fluids were ordered for R10 at her request and that she arranged through dietary to have colas delivered to him, however, she was not able to provide any evidence that R10 was receiving colas prior to his hospitalization. She stated the fluid intake recorded on the MAR would include any type of fluid consumed but does not specify what kind. The facility failed to closely monitor R10's fluid intake and failed to recognize the fact that his	F 327		

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F 327	Continued From page 28 weight loss in 2/10 might have been related to fluid depletion. As a result, R10 became severely dehydrated and was hospitalized with acute renal failure.	F 327	F329	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that six (R8, R14, R32, R40, R70 and R102) out of 36 sampled residents drug regimen was free from	F 329	A. Resident #14, #32, #40, #70 and #102 medication regime was reviewed. Resident #14 had the Hemoglobin (Hgb) A1C test done on 4/30/10 with normal range. Resident #70 has her Hgb A1C test scheduled every 3 months. Resident #32 has not used the anti-anxiety medication in the last 90 days. Waiting attending physician assessment to discontinue the prn medication. Resident #40 has used the anti-anxiety medication. An effectiveness monitoring tool and a behavior tracking form has been initiated. Resident #102 parameters for taking her blood pressure and pulse prior to	

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F 329	Continued From page 29 unnecessary drugs. The facility failed to monitor laboratory values for R8, R14 and R70. The facility failed to have an adequate indication for use and/or monitor the effectiveness of Xanax (anti-anxiety medication) for R32 and R40. Additionally, the facility failed to monitor R102's blood pressure and pulse prior to the administration of the medication Metoprolol. Findings include: 1. Review of R14's April 11, 2010 physician's order record (POR) noted an order for Glycohemoglobin (HgbA1C - blood test which measures blood sugar control over several months) every four months. Record review revealed that the last HgbA1C was completed on 3/26/09. An interview with E1 (administrator) on 4/29/10 at approximately 9 AM confirmed that no additional HgbA1C had been completed since 3/26/09, over one year ago. 2. R40 was admitted to the facility on 12/12/09 after she fell in assisted living. On 12/14/09, the physician ordered Xanax 0.5 mg by mouth every 8 hours PRN (as needed). On 1/23/10, R40 was ordered Xanax 0.25 mg by mouth daily prior to therapy. On 4/29/10 at 6:59 PM, an interview with E3 (Social Worker) revealed they had trouble getting R40 to participate in therapy. R40 would go to therapy and then complained she had a headache. E3 also stated that R40 requested to go to the bathroom a lot. On 4/29/10 at 7:12 PM, an interview with E7 (RN Supervisor) revealed the PRN Xanax was used because R40 asked to go to the bathroom a lot.	F 329	the administration of the medication have been updated in the system. Resident #8 is no longer in the facility. B. Pharmacy consultant has reviewed current residents and recommendations were made as necessary. No discrepancies have been noted. C. SDC/designee will re-educate the professional nursing staff regarding the use of unnecessary drugs. Consultant pharmacist recommendations will be reviewed monthly and presented to physicians for their review. D. DON/designee will audit responses to Consultant Pharmacy reports monthly to ensure follow-through. Variances will be corrected	

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F 329	Continued From page 30 E7 continued to state that the staff took R40 to the bathroom, R40 would get back to the chair and then raise her hand to go to the bathroom again. The staff took R40 to the bathroom but R40 does not void. E7 stated this would go "on and on." When asked for the behavior monitoring sheet E7 said she would try to find them. On 4/30/10 at 7:55 AM, an interview with E8 (staff nurse) revealed she gave R40 the Xanax ordered daily. E8 continued to state R40 was given the Xanax because she cried and does not want to go to therapy and that the Xanax helps with her anxiety. Review of the medical record with E6 (Medical Records) on 4/30/10 at 8:23 revealed the nurses documented the administration of R40's Xanax. The facility did not have a separate monitoring sheet. Review of R40's Medication Administration Sheet revealed the staff documented administering the Xanax PRN and daily. The staff did not document the behaviors presented for the administration of Xanax. At the conclusion of the survey no behavior monitoring sheets were provided. 3. R32 was admitted to the facility on 1/26/10 with a diagnosis of anxiety. Admission orders, dated 1/26/10, included an order for Xanax (antianxiety medication) 0.5 mg by mouth 2 times a day prn (as needed) for anxiety. Review of R32's medication administration records (MAR) from 1/26/10 through 2/28/10 indicated the resident received the prn Xanax on 2/4/10, 2/11/10, 2/22/10, 2/25/10, 2/27/10, and 2/28/10, a total of 6 doses since 1/26/10. These MARs indicated the	F 329	and results reported to the QA committee for review. Attachment #18 and #18A	6/15/10

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resident received the Xanax for anxiety and that it was effective.

On 3/1/10 an order was written for R32 to receive Xanax 0.5 mg every evening at bedtime. There was no indication in the clinical record as to why R32 required the Xanax to be administered every evening at bedtime, nor was there any monitoring of it's effectiveness.

The facility failed to attempt any non-pharmacological interventions prior to using Xanax and failed to monitor it's effectiveness.

4. Review of R70's medication regimen revealed the resident was receiving Pravachol (antilipemic agent) 40 mg daily since readmission to the facility on 10/1/09. The clinical record lacked evidence of a recent blood lipid panel and liver function test (LFT). In an interview with E25 (nurse) on 4/28/10 at 3 PM, she acknowledged the lack of these laboratory tests. Upon review of R70's hospital record, the facility found that the last LFT was dated 10/1/09 (obtained while R70 was in the hospital).

On 4/28/10, E26 (nurse) called the facility's laboratory services provider, who stated they had no record of any LFTs or lipid panel for R70. The facility failed to monitor the effectiveness of and the potential for adverse consequences of the Pravachol that R70 was receiving.

5. R102 was admitted to the facility on 3/8/10 with diagnoses that included hypertension and coronary artery disease. Admission orders, dated 3/8/10 included an order for Metoprolol (lowers blood pressure) 50 mg by mouth twice a day which was to be held if the systolic blood pressure

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(BP) was less than 110 or the heart rate (HR) was less than 55.

Review of the medication administration record (MAR) from 3/8/10 through 4/29/10 lacked documented evidence of the BP and HR having been recorded prior to the administration of the Metoprolol.

On 4/29/10, during an interview with E27 (nurse) she stated that the "system" (facility's computerized MAR) does not ask for this resident's BP and HR to be recorded, but because she has the parameters, she does get them. E27 then showed this surveyor her report sheet for that day where she had documented the BP and HR. After this interview, E10 (nurse) proceeded to add to R102's computerized MAR an area for the BP and HR to be recorded when Metoprolol was given.

6. R8 was admitted to the facility on 5/11/09 and had a diagnosis of hypothyroidism. R8's clinical record contained facility Standing Orders which stated that if the resident was on thyroid replacement therapy with a diagnosis of hypothyroidism "obtain T4,FTI, TSH, and T3RU tests on admission (unless done in the hospital) and annually thereafter."

Review of R8's medication regimen revealed the resident was receiving Levothyroxine Sodium (thyroid product) 100 mcg by mouth daily. The clinical record lacked evidence of any blood work for thyroid function. On 4/30/10 during an interview, E6 (medical records) acknowledged that she was not able to locate any blood work for thyroid function for R8. E6 also stated that she had called the facility's laboratory provider and the hospital and neither place had the blood work.

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F 329	Continued From page 33 The facility failed to ensure that R8 had laboratory blood work necessary to monitor the effectiveness of the Levothyroxine.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding	F 334	F334 A. Resident #31 received the pneumococcal immunization on 4/28/2010. B. A review of current residents was completed. Pneumococcal immunizations have been offered to current residents. C. Staff have been re-educated regarding the process of offering pneumococcal vaccines to residents upon admission. The immunization record form is now part of the admission packet. D. RNAC/designee will audit for compliance weekly x4 then quarterly. Results of	

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F 334	Continued From page 34 the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record reviews and interview, it was determined that the facility failed to re-offer the pneumococcal vaccination to one (R31) of five sampled residents. Findings include: R31 was admitted to the facility on 3/11/05. At	F 334	audit will be reported to the QA committee. Attachments #19 and #19A	6/15/10

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F 334	Continued From page 35 the time of admission, R31 was offered a pneumococcal vaccination, which the resident refused. Record review lacked evidence that R31 was re-offered the pneumococcal vaccination since her refusal at the time of admission in 2005. An interview with the administrator (E1) on 4/28/10 at approximately 2 PM confirmed that the resident was not offered the vaccination since admission.	F 334	F364 A. No residents were affected by the practice. The food was discarded and a new tray was prepared with food at the proper temperature. B. Food temperatures continue to be monitored prior to serving to the residents. C. Dining service staff has been re-educated regarding the proper use of the heat retention system. A test tray is conducted for each meal and monitored for hot food temperatures to be within acceptable temperature range and captured on the shift audit. D. Designee will perform daily audit of food temperatures 5 days/wk x 4 weeks. Variances will be addressed and results reported to the QA committee for review.	
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on temperature readings and tasting of a test tray on 04/29/10 at 5:17 PM, it was determined that the facility failed to provide food at the proper temperature. Findings include: Food temperatures from a regular diet test tray were taken. The tray was delivered by cart to the assisted dining room. The following temperatures were observed; cabbage = 115 degrees Fahrenheit (F), ham = 115 F, broccoli soup = 107 F, and lima beans = 104 F. The above temperatures were luke-warm or cool to the palate when sampled.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371		

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F 371	Continued From page 36 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made in the dietary department and staff interviews, it was determined that the facility failed to prepare, distribute and serve food under sanitary conditions. Findings include: 1. On 4/26/10 at 9:35 AM, a dietary food service employee was asked to confirm the presence of a sanitizing agent (a quaternary ammonia solution) using a test strip in the three compartment sink in the kitchen. The sanitizer concentration was detected at 50 PPM. Another batch of the sanitizer was made and another test strip was used to measure the concentration of the sanitizer detecting approximately 100 PPM. Review of the dietary procedures on the required concentration of the sanitizer posted on the wall revealed that the sanitizer should be at a concentration of 150-400 PPM. The concentrations measured were below the recommended manufacturer's chemical concentration of 150-400 PPM required to sanitize dishes at the three compartment sink. Review of the facility's sanitizer check log revealed that the sanitizer concentration was recorded for the month to be within limits (200-300 PPM).	F 371	Attachment #20 F371 A. Chemical concentrations in the three compartment sink are maintained at the manufacturers recommended range of 150ppm-400ppm. Staff is wearing hair nets correctly to cover all hair while food is prepared, stored and distributed. Air gaps have been installed on the vegetable sinks. B. Sanitary conditions are being maintained in the kitchen area. C. Dining staff have been re-educated regarding proper sanitizing solutions range and proper use of hair restraints. A daily log is continued to be maintained	6/15/10

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F 371	Continued From page 37 An interview with E18 (director of dining) on 4/28/10 revealed that the chemical vendor was contacted and they adjusted the concentrations of the chemicals on the three compartment sink on 4/27/10. The vendor had recalibrated the unit to obtain the proper concentration in the sanitizing unit of the three compartment sink to sanitize pots, pans and kitchen equipment. Facility policy titled "Sanitizing Equipment" review revealed that all personnel were to check the sanitizer for proper concentration and guidelines to maintain the sanitizer between 150-250 PPM. 2. An observation in the Health Center (HC) kitchen on 4/26/10 at 9:30 AM revealed that the hair restraint failed to completely cover E15's (dining staff) hair while prepping food for lunch. Additionally, an observation of the independent main kitchen on 4/26/10 at 10:15 AM, where lunch food is prepared and delivered to the HC kitchen, revealed that E16 and E17 (dining staff) failed to wear a hair restraint which completely covered their hair while prepping food for lunch. Facility policy review for personal hygiene included the use of hair restraints as part of their requirements while food was prepared, stored, and distributed. Staff interviews with E18 (dining director) confirmed the findings. 3. On 4/26/2010, observations of both vegetable sinks on the HC kitchen and the independent kitchen revealed the drain pipes to be directly piped through the wall and none had the required air gap per the Delaware food code.	F 371	for proper sanitizing solution range, and proper use of hair nets are noted for compliance on the shift audit tool. D. DSD/designee will be performed daily audits for compliance 5 days/week x 4 weeks. Results of audits will be reported to the QA committee for review. Attachments #20 and # 21	6/15/10

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F 371	Continued From page 38 An interview with E18 (dining director) during the observation revealed that the drain pipes from the vegetables/food prep sinks had always been piped to the walls and never had an air gap.	F 371		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to assist in obtaining dental services for one resident (R70) out of 36 sampled residents. Findings include: On 4/27/10 during an interview, R70 was observed without dentures. R70 stated that her top denture was good, however the lower denture did not fit properly. R70 stated that she had last seen the dentist last summer and had told him that the lowers did not fit properly. R70 stated that he said he'd be back, however she has not seen him since. R70 also stated that she had asked a	F 411	F411 A. Resident #70 was seen by the dentist at the facility on 5/4/2010; she was then seen, upon recommendation of the dentist, by the oral surgeon on 5/18/2010. She was seen again by the dentist on 5/28/2010 and he made an adjustment to the dentures so resident can wear them. B. No other residents have dental needs currently C. Resident dental concerns are discussed 5x/wk at daily morning meeting with the IDT. A dental tracking tool has been developed for use and is being followed to ensure follow-up of any issues by the Social Service Coordinator/designee. Nursing staff have been	

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F 411	Continued From page 39 nurse about seeing the dentist and was told that they would get in touch with him. During an interview with E3 (Social Worker) on 4/29/10 at 4:45 PM, E3 stated that the facility had a dentist that comes to the facility to provide care. She stated that she was not aware of R70 having any dental concerns. E3 reviewed the facility's interdisciplinary notes and found a note dated 9/8/09 that stated R70 was complaining of lower denture discomfort and that a dental consult was ordered. It was determined that before R70 was seen by the dentist, she was sent out to the hospital on 9/19/09. After R70's readmission to the facility on 10/1/09 the facility failed to follow through with the dental consult. E3 acknowledged that the facility failed to follow through with the consult and stated she would call the dentist as soon as possible.	F 411	educated by the SDC/designee to alert Dentist/attending MD/social service for any dental problems noted by residents. D. Audit of the tracking log will be done monthly by the Social Service Director and results reported to the QA committee. Attachments #7 and #22	6/15/10
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation	F 425	F425 A. Resident #88 is receiving the correct dosage of her medication. The Attending Physician was notified on 4/29/10 and the Physician Order (PO) was clarified. B. Current resident's medications have been reviewed by the consultant	

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F 425	Continued From page 40 on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview with the pharmacist, it was determined that the facility failed to ensure the accurate dispensing and administration of a supplement to meet the needs of one (R88) out of 36 sampled residents. Findings include: During the medication administration observation on 4/29/10 at approximately 9 AM, E8 (nurse) gave R88 one capsule of fish oil 1,000 mg supplement by mouth. Review of the original physician's order, dated 9/19/09, noted fish oil 4 tabs by mouth daily. Review of the 4/10 physician's order record noted "fish oil 1,000 mg. 1 capsule (s) PO (by mouth) 1 time a day at 9 AM. Special instructions: fish oil 4 tabs PO daily . Supplement 9/20/09-5/10/10." An interview with E2 (corporate nurse) on 4/29/10 at 10 AM confirmed that facility failed to follow the physician's order for four tablets of the fish oil. Subsequent to the above observation, the attending physician for R88 wrote an order for fish oil 1,000 mg. one capsule four times a day by mouth. An additional interview with E19 (facility's pharmacist) on 5/3/10 at approximately 9 AM revealed that the pharmacy failed to clarify the order, thus, the pharmacy has only dispensed one fish oil capsule per day since R88's admission in September 2009, a total of approximately seven months.	F 425	pharmacist. No discrepancies were found. C. DON/designee will review medication orders upon admission and random reviews continue to ensure accuracy of orders. Professional staff have been re-educated regarding medication order entry. D. DON/designee will audit new resident's medication orders for accuracy for one month. Results will be reported to the QA committee. Attachments #7 and # 23	6/15/10

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F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that during the monthly drug regimen review the consultant pharmacist identified and reported irregularities to the attending physician and the director of nursing, and these reports were acted upon for seven (R8, R14, R32, R40, R51, R70, and R102) out of 36 sampled residents. Findings include: Cross refer F329, example #3 1. Review of R32's clinical record revealed that monthly Medication Regimen Reviews (MRR) were completed for 3/10 and 4/10. Although the licensed pharmacist noted on the 4/10 MRR that R32 was receiving Xanax, he failed to identify that the facility was not monitoring the indication for it's use or it's effectiveness. Cross refer F329, example #4 2. Review of R70's clinical record revealed that monthly Medication Regimen Reviews (MRR) were completed from 10/09 through 4/10. The	F 428	F428 A. Residents #14, #32, #40, #70 and #102 medications have been reviewed and necessary parameters are being maintained. Resident #14's monitoring test of Hgb A1C was done on 4/30/10. Resident #32 has a tracking form for the effectiveness of the use of medication. Resident #40 has a tracking form for the effectiveness of the use of the medication and a tracking form for the behaviors. Resident #70 had a lipid panel and liver function tests done on 4/29/10. Resident #102 has parameters included in the system to monitor her blood pressure and heart rate prior to the administration of the medication that lowers her	

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F 428	Continued From page 42 licensed pharmacist did not identify that the resident was receiving Pravachol (antilipemic agent) and that the facility failed to obtain a lipid panel and liver function tests. Cross refer F329, example #5 3. Review of R102's monthly MRR revealed that the licensed pharmacist did not identify that the facility failed to have documented evidence of the monitoring of blood pressure and heart rate prior to the administration of Metoprolol (lowers blood pressure). Cross refer F329, example #2 4. On 12/14/09 the physician ordered Xanax 0.5 mg by mouth every 8 hours PRN (as needed) for R40. On 1/23/10 R40 was ordered Xanax 0.25 mg by mouth daily prior to therapy. Review of the monthly Medication regimen Review (MRR) sheet revealed the pharmacist failed to identify the lack of facility monitoring for the use of the anti-anxiety medication Xanax for R40. Cross refer F329, example #1 5. Review of R14's April 11, 2010 physician's order record (POR) noted an order for Glycohemoglobin (HgbA1C) every four months. Record review revealed that the last HgbA1C was completed on 3/26/09 which was confirmed during an interview with the administrator (E1) on 4/29/10 at approximately 9 AM. Review of the monthly medication regimen review from 10/09 through 4/10 revealed that the consultant pharmacist failed to identify the lack of monitoring of HgbA1C. Findings were reviewed with the facility on 4/30/10.	F 428	blood pressure. Resident #8 and Resident #51 no longer resides in the community. B. Consultant Pharmacist drug reviews are being monitored and recommendations are communicated to physician for review. C. Pharmacy review was completed by the consultant pharmacist. SDC/designee will re-educate professional nursing staff regarding the importance of monitoring lab values and blood pressures relevant to drug use. Also the use of psychotropic medication and appropriate drug regiments. D. DON/designee will audit follow up action to monthly consultant pharmacy reports for compliance. Results	

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F 428	Continued From page 43 6. Record review revealed that R51 was receiving Seroquel (antipsychotic) 25 mg. (milligram) by mouth at bedtime since 10/1/09. Review of the Consultant pharmacist's monthly report revealed that on 1/21/10 and 4/9/10 a recommendation was made for a dose reduction (to 12.5 mg on odd days and 0.25mg on even days) of R51's Seroquel. The facility failed to respond to these recommendations. On 4/30/10, after being questioned by the surveyor, the facility faxed the report to the physician, who then responded to the recommendation. Interview with the Corporate Nurse (E2) on 4/29/10 and 4/30/10 confirmed the above findings. Cross refer F329, example #6 7. Review of R8's clinical record revealed that monthly Medication Regimen Reviews (MRR) were completed from 10/09 through 4/10. The licensed pharmacist did not identify that the resident was receiving Levothyroxine (thyroid product) and that the facility failed to obtain necessary thyroid function tests.	F 428	will be reported to the QA committee. Attachment #18 F441 A. The concentration of chemicals used in the laundry system ensures that the laundry will be sanitized. The contractor that supplies the chemicals for our laundry has verified that bleach in both washers is provided at 100 parts per million. The door between the soiled and clean linen rooms is closed. Resident #13 is receiving wound care that meets infection control standards. Residents dressing changes are performed using aseptic technique. The C.N.A	6/15/10
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		

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F 441	Continued From page 44 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to follow recommended CDC guidelines for washing of soiled linen. Additionally, the facility failed to follow proper handwashing protocol and food handling practices. Findings include:	F 441	observed picking up the resident's sandwich without a barrier was educated on proper food handling the same date. The formulas used in each wash event are posted for all laundry. The door between clean and soiled laundry rooms is observed by laundry personnel to ensure the door remains closed. B. Laundry staff has been educated regarding chemical concentration in the laundry system and the importance of closing the door between clean and soiled laundry rooms. Professional nursing staff have been re-educated regarding proper dressing change techniques. C. The formulas used in each wash event are posted for all laundry. The door	

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F 441	Continued From page 45 1. Observations on 4/19/10 at 12:30 PM of the boiler room washer hot water tank temperatures revealed the temperature to be 110 degrees Fahrenheit. Interview with E13 (Maintenance director) and E14 (Maintenance supervisor) revealed that this temperature was the maximum temperature of the washer water. E14 stated there may be a booster at the washers to raise the temperatures to at least 160 degrees Fahrenheit. The concentration of the chemicals used at the washer to sanitize and get rid of most common disease was unknown. E13 was not aware that the chemicals used in the washers provided the necessary concentration of the chlorine to meet the regulations. Interview with E13 on 4/30/2010 at 10:17 AM revealed that he had spoken with the chemicals vendor and they provided instructions to the facility how to test the temperature of the washer to determine if the water temperature was 160 degrees Fahrenheit as is required by state regulations. E13 was observed at the machines using the procedures provided but they did not work during the test. The manufacturer's specifications for the washers, listing a booster within the machine, were requested on 4/29/10 but not provided. Procedures for the laundry were requested from E13 and E2 but were not provided. 2. The door between the soiled linen room and the clean room of the laundry was observed open on 4/29/10 at 12:30 PM. This procedure fails to provide a positive pressure area for the clean linen to be maintained free from contaminated air from the soiled room as this room was no longer	F 441	between clean and soiled laundry rooms is observed by laundry personnel to ensure the door remains closed. Residents dressing changes are performed using aseptic technique. D. Housekeeping supervisor will monitor chemical concentration in laundry system and monitor door closures to ensure compliance 5 days/week x 4 weeks. SDC/designee will randomly audit dressing change procedures with professional nursing staff to ensure proper techniques are being utilized. Results of audits will be reported to the QA committee for review.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 46 under negative pressure. Interview with maintenance (E13 and E14) during the tour confirmed this finding. 3. The facility's policy and procedure for handwashing stated "Hands should be washed ... Before and after each procedure or task, Before and after handling medications, Before and after the use of gloves..." The Lippincott Manual of Nursing Practice 7th Edition stated "Equipment Unsterile- gloves, plastic bag for discard dressings, tape, proper size and type, pads to protect patient's bed. Procedure 5. Wash hands thoroughly. 6. Place dressing supplies on a clean, flat surface (over bed table). 7. If linen protection is needed, place clean towel or plastic bag under part of body where wound is located. 9. Place disposable bag nearby to collect soiled dressings. 10. Determine how many and what types of dressings are necessary. Open each dressing by peeling apart the edges of package." R13 had a physician order dated 11/25/09 stating "Dressing-gauze 1 application topical to heel right. Cleanse area, pat dry, apply dry dressing to right heel. Allow eschar to dry and come off at edge. Change daily." On 4/28/10 at 4:00 PM E9 (LPN) was observed doing a dressing change to R13's right heel. E9 placed the dressings on top of the tray table and took out what he needed. E9 then donned gloves. E9 left the bed in low position and got down on one knee on the floor to do the dressing change. E9 removed scissors from his pocket and cut off the old dressing from R13's right heel and placed them on the floor instead of in a	F 441	Attachments #9, #11, #24, # 25, #26	6/15/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085032	A. BUILDING _____ B. WING _____	05/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 47 plastic trash bag. E9 did not clean his scissors before placing them back in his pocket. E9 changed his gloves and did not wash his hands. E9 opened a sterile 4x4 and laid it on the bed. E9 did not set up a clean area to work from, instead he used R13's bed. After cleansing the wound with normal saline and 2x2 pads, E9 discarded the contaminated 2x2 pads on the floor. E9 then opened the Kling wrap and unrolled the Kling (rolled guaze) wrap using one gloved hand and forearm above his other hand. E9 did not wash his hand after removing the glove. E9 put the 4x4 over the wound and wrapped R13's foot with Kling. Then E9 removed his glove and replaced R13's boot that was dirty. E9 put the soiled dressing in a plastic bag and dropped it in the trash can. E9 did not wash his hands. After the completion of the dressing change, E9 assisted R13 into her wheelchair and wheeled her to the hallway. E9 then opened the medication cart and began to give R13 medication without first washing his hands. The surveyor immediately reviewed observations with E9. E9 confirmed surveyors observation and immediately washed his hands. 4. During dining observations in the assisted dining room on 4/26/10, E28 (Certified Nurse Aid) was observed handling R65's food with her bare hands. E28 was observed picking up the resident's sandwich without providing a barrier. When she put the sandwich down between bites, she was observed touching her face.	F 441	F467 A. Bathroom exhaust vents in resident's Rm. 218 and Rm. 221, exhaust vents of East Wing common tub room, exhaust vents in room of the HC kitchen, the Independent Living main kitchen janitor/utility room, and the East wing housekeeping closet are	
F 467 SS=B	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC	F 467		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085032	A. BUILDING _____ B. WING _____	05/03/2010

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F 467	Continued From page 48 The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observations of resident bathrooms, the kitchen utility rooms, and staff interviews, it was determined that the facility failed to maintain adequate ventilation as reflected by malfunctioning exhaust vents. Findings include: During the environmental tour of the facility with maintenance staff, E13 and E14, on 4/29/10 at 11:30AM, the bathroom exhaust vents in resident rooms 218, 221 were found to have no negative air flow exiting the room through the ceiling exhaust unit. Additionally, the exhaust vents of the East wing common tubroom were not working. Interview with the facility's maintenance director, E28, on 4/30/2010 confirmed that the vents were not working and the motor for the vents had been repaired. 2. On 4/26/10 at 9:30 AM, the janitor or utility room of the HC kitchen had no negative air flow exiting the room through the ceiling exhaust vent. The exhaust vent was venting air into the utility room, rather that exhausting the dirty air out of the utility room. The independent kitchen janitor or utility room had no exhaust vent. Dietary staff, E18, was interviewed to confirm these findings. 3. On 4/29/2010 at 11:35AM, the exhaust vent of the East wing housekeeping closet was not	F 467	functioning properly. The exhaust vents for resident's bathroom as well as the exhaust vent of the East wing housekeeping closet are powered by the same exhaust motor. The motor in question was replaced on 5/12/2010. B. All the exhaust fan motors were inspected by the facility's maintenance supervisor and a representative from CJM Services, a licensed electrical/mechanical contractor. C. Exhaust vents will be audited by a maintenance tech to ensure proper function. D. Exhaust vents will be added to the preventative maintenance audit to ensure proper function. Audits will be conducted 5	

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F 467	Continued From page 49 working.	F 467		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and record review on 4-30-10, it was determined that the facility failed to maintain a quality assessment and assurance (QAA) committee that met quarterly consisting of the physician designated by the facility and the Director of Nursing (DON). Additionally, the QAA committee failed to develop an appropriate plan	F 520	days/week x 4 weeks. Results of this audit will be presented to the QA committee for review. Attachments #27 and # 28 F520 A. An action plan or Process Improvement Program has been developed to correct the problem of untimely and inaccurate weights of residents. The Weight Protocol has been implemented and the licensed nursing staff has been educated. The Process Improvement Subcommittee Chair person will be responsible for making recommendations to ensure that appropriate actions are implemented to	6/15/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 520	Continued From page 50 of action to correct problems that were identified regarding obtaining accurate weights. Findings include: 1. Based on interview with E1 on 04/30/10, while reviewing the QAA committee sign-in sheets, it was revealed that the physician assigned to the QAA committee did not attend three of the last five meetings. The missed meeting dates included; 01/21/10, 07/30/09, and 04/28/09. The Director of Nursing assigned to the QAA committee did not attend two of the last five meetings. The missed meeting dates include; 04/29/10 and 01/21/09. Cross refer to F325 2. During an interview with E5 (dietitian) on 5/3/10, she stated that problems with obtaining accurate weights for residents was discussed in the QAA committee meetings either in 1/10 or 2/10, however, no plan of correction was implemented.	F 520	improve services, and monitor the process for effectiveness. All members will present feed back and solutions to address the weight issue. The weight action plan will be part of the Quality Assurance/Quality Improvements Program under the Quality of Care Subcommittee to meet regulatory standards. B. Monthly and quarterly QA committee meeting has been scheduled. C. QA committee members will be educated on the importance of routinely scheduled meetings and member attendance. Education will also be provided on the function of the QA committee. Education will be provided by Presbyterian Senior	

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F 520	Continued From page 50 of action to correct problems that were identified regarding obtaining accurate weights. Findings include: 1. Based on interview with E1 on 04/30/10, while reviewing the QAA committee sign-in sheets, it was revealed that the physician assigned to the QAA committee did not attend three of the last five meetings. The missed meeting dates included; 01/21/10, 07/30/09, and 04/28/09. The Director of Nursing assigned to the QAA committee did not attend two of the last five meetings. The missed meeting dates include; 04/29/10 and 01/21/09. Cross refer to F325 2. During an interview with E5 (dietitian) on 5/3/10, she stated that problems with obtaining accurate weights for residents was discussed in the QAA committee meetings either in 1/10 or 2/10, however, no plan of correction was implemented.	F 520	Living's Health Center Support Manager. D. A review of the facilities QA committee attendance record as well as minutes will be reviewed periodically by the Health Center Administrator to ensure compliance with committee requirements. The result of the audits will be presented to the QA committee. Attachments #13, #14, #15 and #29	6/15/10

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085032	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 5/3/2010

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WESTMINSTER VILLAGE HEALTH	**1175 MCKEE ROAD DOVER, DE**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on clinical record review and interview it was determined that the facility failed to accurately code the Minimum Data Set (MDS) assessments for two (R40 and R 51) out of 36 residents sampled. Findings include:

1. Review of R40's 3/3/10 MDS assessment revealed the facility coded R40's assessment of side rails in section P4 "Restraint and other devices" instead of in Section G6 "Modes of transfers" as an enabler.

Interview with E8 (LPN) and E10 (RN supervisor) on 4/30/10 at 12:15 PM revealed R40 uses the side rails as an enabler.

Interview with E4 (MDS Nurse) on 4/30/10 at 11:45 AM revealed the MDS assessment inaccurately documented the siderails under restraints instead of under Modes of transfers as an enabler.

2. Observations of R51's bed during the survey revealed that the bed had one ½ upper side rail on each side of the bed. An interview with nursing staff (E8) on 4/28/10 revealed that the resident used the side rails to move side to side in the bed and was an enabler for R51. Other interviews with hospice aides (E32) and facility certified aides (E24) confirmed the resident used the bed rails as enablers while care was being provided in the bed.

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085032	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 5/3/2010

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F 278	Continued From Page 1 Review of R51's Physician Order Record (POS) for April 2010 indicated R51 to have bilateral upper ½ side rails as an enabler. Review of R51's most recent annual MDS assessment dated 3/4/10 failed to indicate the use of the side rails as an enabler in Section G6, "Modes of Transfer" for use of "bed rails used for bed mobility or transfer." An interview with corporate nursing staff (E31) on 4/30/10 at 1:30 PM confirmed that the facility failed to code the use of the side rails for bed mobility in Section G6 on the above MDS assessment.

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Division of Long Term Care
Residents Protection

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STATE SURVEY REPORT

NAME OF FACILITY: Westminster Village Health Center

DATE SURVEY COMPLETED: May 3, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey was conducted at this facility from April 26, 2010 through May 3, 2010. The deficiencies contained in this report are based on observations, staff and resident interviews, clinical record reviews, review of facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was fifty-eight (58). The survey sample totaled thirty six (36) residents.	
3201	Skilled and Intermediate Care Nursing Facilities	
3201.1.0	Scope	
3201.1.2	Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.	

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	This requirement is not met as evidenced by: Cross-refer to CMS 2567-L, survey date completed 5/3/10, F241, F253, F278, F279, F280, F281, F309, F314, F318, F325, F327, F329, F334, F364, F371, F411, F425, F467, examples #2 and #3, F428, F441, and F520.	3201.1.2 Cross refer to the CMS – 2567 –L Plan of Correction submitted on 6/1/10 for survey ending 5/3/10 on F241, F253, F278, F279, F280, F281, F309, F314, F318, F325, F327, F329, F334, F364, F371, F411, F425, F467, Examples #2 and #3, F428, F441, and F520
3201.7.0	**Plant, Equipment and Physical Environment**	
3201.7.4	**Physical Environment Requirements**	
3201.7.4.3	**Bathrooms**	
3201.7.4.3.1	**Bathroom walls and floors shall be impervious to water. Bathrooms shall have at least one window or mechanical ventilation exhausted to the outside.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 5/3/10, F467, Example #1.	3201.7.4.3.1 Cross refer to the CMS – 2567 –L Plan of Correction submitted on 6/1/10 for survey ending 5/3/10 on F467, Example #1
3201.7.5	**Kitchen and Food Storage Areas.** **Facilities shall comply with the Delaware Food Code.** Based on the dietary observation during the	

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	survey, it was determined that the facility failed to comply with sections: 2-402.11, 4-501.114, 5-402.11 of the State of Delaware Food Code. Findings include: **Hair Restraints** **2-402.11 Effectiveness.** **(A) Except as provided in ¶ (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey completed 5/3/10, F371, Example #2. **4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness** **A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at exposure times specified under ¶ 4-703.11(C) shall be listed in 21 CFR 178.1010 Sanitizing**	3201.7.5 Cross refer to the CMS – 2567 –L Plan of Correction submitted on 6/1/10 for survey ending 5/3/10 on F371, Example #2

NAME OF FACILITY: Westminster Village Health Center

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	solutions, shall be used in accordance with the EPA-approved manufacturer's label use instructions, and shall be used as follows: **(C) A quaternary ammonium compound solution shall:** **(1) Have a minimum temperature of 24°C (75°F),** **(2) Have a concentration as specified under § 7-204.11 and as indicated by the manufacturer's use directions included in the labeling, and** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey completed 5/3/10, F371, Example #1. **5-402.11 Backflow Prevention.*** **(A) Except as specified in ¶¶ (B) and (C) of this section, a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey completed 5/3/10, F371, Example #3.	5-402.11 Cross refer to the CMS – 2567 –L Plan of Correction submitted on 6/1/10 for survey ending 5/3/10 on F371, Example #1. 5-402.11 Cross refer to the CMS – 2567 –L Plan of Correction submitted on 6/1/10 for survey ending 5/3/10 on F371, Example #3.

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STATE SURVEY REPORT

NAME OF FACILITY: Westminster Village Health Center

DATE SURVEY COMPLETED: May 3, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.7.6	**Sanitation and Laundry**	
3201.7.6.3	**For on-site laundry processing, the facility shall:**	
3201.7.6.3.1	**Provide a room under negative air pressure for receiving, sorting, and washing soiled linen.**	
3201.7.6.3.1.1	**If hot water is used for destroying micro-organisms, washers must be supplied with water heated to a minimum of 160° F.**	
3201.7.6.3.1.2	**If low temperature laundry cycles are used, a total available chlorine residual of 50-150 ppm must be present and monitored during the wash cycle.**	
3201.7.6.3.2	**Provide a room under positive air pressure for drying and folding clean linen, equipped with a hand washing sink.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 5/3/10, F441, Example #1, 2.	3201.7.6.3.2 Cross refer to the CMS – 2567 –L Plan of Correction submitted on 6/1/10 for survey ending 5/3/10 on F441, Example #1, 2

Submitted by: [signature] 6/15/10